OHIO MEDICAID ASSESSMENT SURVEY

2012

Taking the pulse of health in Ohio

Ohio Department of Mental Health

MEDICAID RECIPIENTS WITH FUNCTIONAL IMPAIRMENT DUE TO A MENTAL HEALTH CONDITION OR EMOTIONAL PROBLEM

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MEDICAID A KEY DRIVER

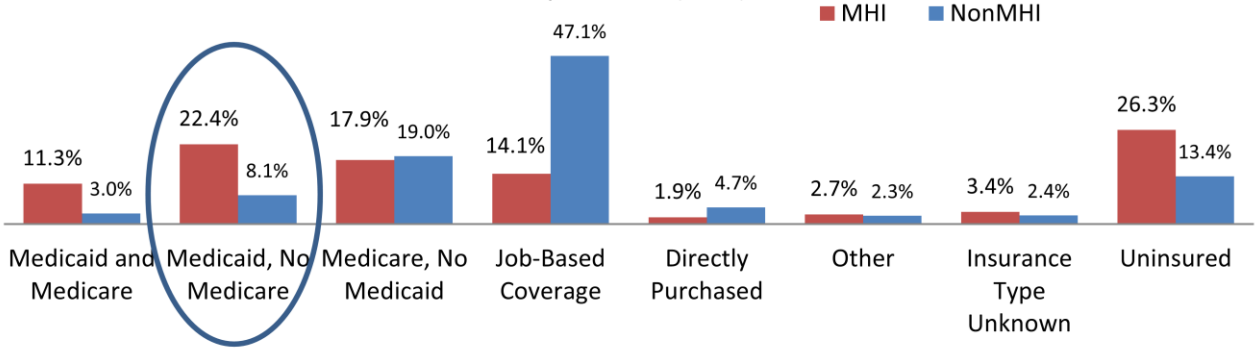
Medicaid is a key driver in Ohio's public mental health system. Of the 109,100 adults with severe mental disability (SMD) who received publically subsidized care in State Fiscal Year 2012, seventy-two percent (72%) received at least one clinical service covered by Medicaid.[1] For adult Ohioans with SMD[2] and Medicaid coverage, caseload sizes increased by 5% between 2010 and 2012. Due to the important role Medicaid plays in financing clinical care for adults with SMD, the 2012 Ohio Medicaid Assessment Survey (OMAS) included a measure of the number of days in the past 30 days when a mental health condition or emotional problem kept adults from doing their work or other usual activities. Adults who reported 14 or more days of functional impairment are identified as adults with **m**ental **h**ealth-related **i**mpairment (MHI).

OHIOANS WITH 14 OR MORE MENTALLY DISTRESSED DAYS

Survey results indicate that in 2012, 6.6% of Ohioans (approximately 567,284 adults age 19 and older) reported MHI. In 2008 and 2010 administrations of the Ohio Family Health Survey, the estimate mental health-related impairment (MHI) in the general population of adults 18 and older was 6.6% and 8.8%, respectively. The 2010 peak of 8.8% may well be related to psychological and emotional stress associated with Ohio's economic downturn.[3]

After identifying the population of interest in the OMAS dataset as adults with MHI between the age of 19 and 64, analysts at the Ohio Department of Mental Health (ODMH) compared the types of insurance coverage reported by the MHI group to that reported by the general population or adults without MHI. Results are shown in Figure 1.

Figure 1
Distribution of Coverage for Adults with and without Mental Health-related Impairment (MHI)



OMAS Ohio Medicaid Assessment Survey | Ohio Office of Medical Assistance | MedTAPP | Ohio Colleges of Medicine Government Resource Center | Ohio Department of Health

Adults with MHI are more likely than the general population to rely on coverage through public insurance programs or to have no coverage at all. Smaller proportions of adults with MHI report having job-based coverage. In the "Medicaid no Medicare" group, an estimated 126,858 people were identified as adults with MHI, compared to an estimated 654,316 of the general population.

THE POPULATION OF INTEREST: ADULTS WITH MHI

Adults between the age of 19 and 64 in the "Medicaid no Medicare" group with and without MHI were compared on measures of race, gender, age, income level, Medicaid Region, and County Type. The two groups—MHI and nonMHI—differed on most demographics (Tables 1, 2 and 3). In the MHI group, a larger proportion of the adults were White (77.9%) compared to the nonMHI (71.7%). The MHI group had more men (35.3%) than the nonMHI group (29.1%). The age groups differed in that the adults with MHI were over-represented in the 35-64 age range. A greater proportion of adults with MHI reported income levels ≤100% and ≤138% FPL. Compared to nonMHI, the MHI group was over-represented in the North West, South West and South East Medicaid Regions.

HOW DO ADULTS WITH MHI COMPARE TO OTHERS IN THE MEDICAID ONLY RISK POOL?

Comorbid Physical Health Conditions

On measures of health, higher proportions of the MHI group with "Medicaid no Medicare" coverage reported histories of obesity, hypertensive disease, heart attack, coronary heart disease, congestive heart failure, stroke, diabetes, and cancer. These findings are supported by national and state general population studies[4,5] indicating extensive physical health comorbidities among adults with MHI. Current findings provide further evidence supporting implementation of Ohio Medicaid Health Homes for adults with serious and persistent mental illness. In Fiscal Year 2013, Ohio Medicaid and Department of Mental Health teamed up to create integrated physical and behavioral health care "homes" for adults with SMD.[6]

Risk Behaviors

A larger proportion of adults with than those without MHI reported current cigarette use (58.5%, 46.8%). Adults with MHI also differed from the nonMHI group on misuse use of prescription pain medication and the frequency of moderate to vigorous physical activities. Similar proportions of adults with and without MHI reported binge drinking (Figure 2).

Table 1. Gender and Racial Profile of Adults with and without MHI

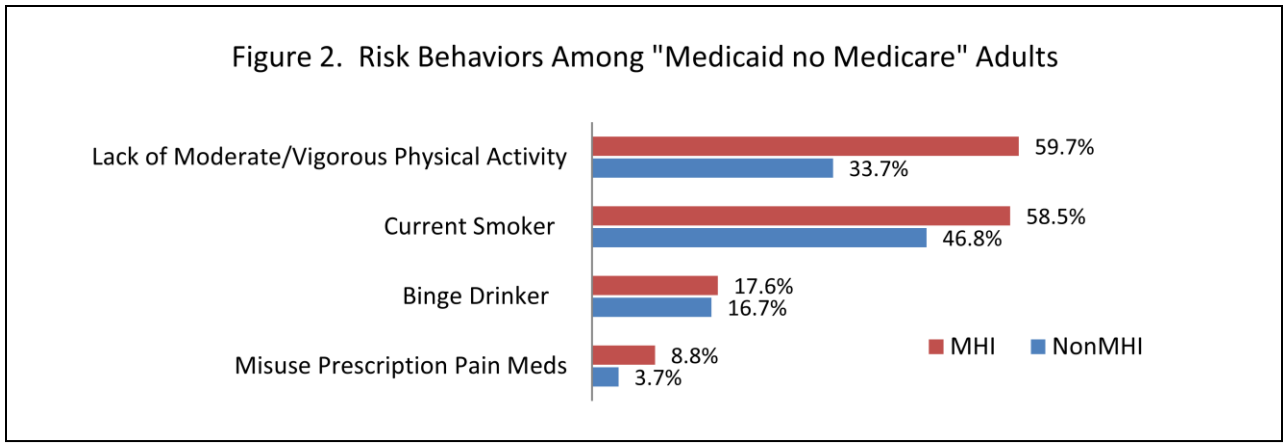
	Gender		Race		
	Male	*Female*	*White*	*Black*	*Other*
MHI	35.3%	64.7%	77.9%	17.8%	4.2%
NonMHI	29.1%	70.9%	71.7%	22.0%	6.2%

Table 2. Age and Income Distributions of Adults with and without MHI

	Age					Income	
	19-24	*25-34*	*35-44*	*45-54*	*55-64*	*≤100 FPL*	*≤138 FPL*
MHI	10.9%	22.1%	28.2%	24.8%	13.9%	81.2%	91.0%
NonMHI	22.7%	35.6%	20.0%	14.2%	7.6%	68.8%	81.8%

Table 3. Medicaid Region Distribution of Adults with and without MHI

	Medicaid Region							
	NW	*NE*	*NC*	*EC*	*C*	*WC*	*SW*	*SE*
MHI	13.6%	12.4%	6.4%	11.2%	17.3%	10.9%	19.2%	8.5%
NonMHI	9.3%	17.6%	5.6%	13.2%	18.8%	11.2%	17.7%	6.5%



Dental Care

A larger percentage of the MHI group with "Medicaid no Medicare" coverage rated their dental and gum health as fair or poor compared to the nonMHI group (52.3%, 33.8%). Although similar proportions of the MHI and nonMHI groups (89.6%, 89.8%) said they had dental coverage, 31.9% of adults with MHI said they needed dental care in the past 12 months and were unable to get it, compared to 20.2% of the nonMHI group.[7] Similar proportions of the MHI and the nonMHI groups indicated "no insurance/insurance didn't cover care" as the major barrier to dental care (48.3%, 46.6%).

Access Issues

Adults with MHI and those without in the "Medicaid no Medicare" coverage group were alike in what they reported as their usual source of care. The majority of adult in both groups (80.6% with MHI, 80.0% without) reported that they received care at a clinic, health center, doctor's office, or hospital out-patient setting. Smaller percentages (15.6% with MHI, 14.7% without) reported using a hospital emergency room as their usual source of care. The remainder (3.8%, 5.3%) reported no usual place of care, some other place of care, didn't know or refused to answer. Among those who have one of these sources of usual care and a personal doctor or nurse, 59.3% with and 43.5% without MHI said that their health care provider had asked whether they "felt sad, empty, or depressed" in the past 12 months. Among those with MHI whose usual care source was a clinic, health center, doctor's office or hospital outpatient setting, 26.8% reported lack of access to needed mental health care. Compared to nonMHI adults, a greater proportion of adults with MHI reported it was harder to get medical care now than three years ago (27.6%, 18.6%). At the same time, a segment of the MHI group (compared to nonMHI) said it was *easier* to get care now (30.3%, 21.1%). Whether current access to care is harder or easier, however, a much higher proportion of adults with MHI said they were having problems paying their medical bills (46.5%, 25.4%).

KEY CONSIDERATIONS

- Adults with MHI are a distinct demographic group within the Medicaid population, in that there are greater proportions who are White, middle-aged males living at or below 100% and 138% FPL, located in the North-West, South-West, and South-East regions of the state. ***Cultural sensitivity, particularly as it relates to perceptions of stigma, is paramount for successfully engaging this group in behavioral health treatment.***

- The disproportionate number of people in the MHI group with serious, chronic physical health conditions is not surprising given the high proportion of low income, middle-age adults with untreated gum and dental problems engaging in risky health behaviors such as smoking, prescription medication abuse, and not exercising regularly. Between 47% and 59% of adults in the "Medicaid no Medicare" coverage group are current smokers, regardless of MHI status. ***Prevention, early intervention and wellness programs are critically necessary to mitigate the impact of costly, chronic physical health conditions.***

- The access problems for adults with MHI are varied. The majority has a usual source of physical health care other than emergency rooms, and their outpatient providers recognize the need to screen them for mental health issues. Nevertheless, just under one-third of the MHI group report they are unable to obtain mental health treatment. This group is significant because they are appropriate candidates for integrated care Medical Homes, but they are unlikely to be found in behavioral health settings. ***Access to mental health treatment could be improved through health homes for adults with chronic physical health conditions that integrate behavioral health services.***

SOURCES CITED

[1]Ohio Department of Mental Health, Multi-Agency Community Services Information System (MACSIS) data base.

[2]Definitional criteria for Serious Mental Disability (SMD) can be found on page 16 of Definitions: Data Entry Field Specifications for Integrated OH BH Forms, located at http://mentalhealth.ohio.gov/assets/research-evaluation/Outcomes/oh-bh-field-definitions.pdf.

[3]Sweeney HA and Gitter R. (2013). Unemployment and Community-based Mental Health Services: The Accessing by Medicaid Enrollees in Ohio Before and During the Great Recession. Manuscript in Review. Ohio Department of Mental Health.

[4]Colton CW & Manderscheid RW. (2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Prevention of Chronic Disease,* 3(2). Accessed on 10/21/09 at: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

[5]2008 Family Health Survey: Special Population Report. Ohio Department of Mental Health. http://mentalhealth.ohio.gov/assets/tsig/ohfs-special-population-report-2008.pdf.

[6]http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.html.

[7]Dental care is part of the standard Medicaid benefit package. Therefore, those reporting Medicaid with no dental coverage either had a limited Medicaid benefit plan such as Medicare Premium Assistance or Family Planning, or did not fully understand their health benefits.

More information about OMAS, including the data and electronic versions of reports and research briefs, are available online at: http://grc.osu.edu/omas/

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